

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN6101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER BROOKWOOD NURSING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During a complaint investigation at Brookwood Nursing Center, Inc. on January 17, 2012, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes. C/O: #29136	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Administrative

2.2.12

STATE FORM

6899

ELVC11

If continuation sheet 1 of 1